State Employee Benefits Committee
May 24, 2010, 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on May 24, 2010 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, OMB, Director, Statewide Benefits
Faith Rentz, OMB, Statewide Benefits
Ann Skeans, OMB, Statewide Benefits
Mary Thuresson, OMB, Statewide Benefits
Casey Oravez, OMB, Financial Operations
Teri Strawder, OMB, Statewide Benefits
Aaron Schrader, OMB, Statewide Benefits
Terry Mullaney, OMB, PHRST
Mike Morfe, AON Consulting
Carolyn Berger, Justice, Supreme Court
Russ Larson, Controller General
Karen Weldin Stewart, Insurance Commissioner
Linda Nemes, Department of Insurance
Nick Adams, State Treasurer's Office
Henry Smith, DHSS, Public Health
Dave Craik, Office of Pensions
Andrew Kerber, Department of Justice
Chris Ulrich, U of D
Toni A. Reed, U of D
Zach March, Alere
Elizabeth Piazza, Alere
Lisa Carmean, City of Milford
Tim Barchak, DSEA
Jim Testerman, DSEA, retired
Mike North, Aetna
Katherine Impellizzeri, Aetna
Drew Brancati, Blue Cross Blue Shield DE
Faith Joslyn, Blue Cross Blue Shield DE
Jay Reed, Blue Cross Blue Shield DE
Kathleen R. Sullivan, DRSPA
Sandy Richards, AFSCME
John Kenyon, AFSCME
Vincent McCann AFSCME
Joe Morocco, HMS
David Leiter, State Employee, DHSS
Dr. Kaplan, Blue Cross Blue Shield DE
Chris Alrich, Blue Cross Blue Shield DE

Agenda Items Discussed:

Introductions/Sign In

Ms. Visalli called the meeting to order at 2:05 p.m. Introductions around the room followed.

Directors Report

Ms. Lakeman gave an overview on Open Enrollment which ended May 19th. There were 1,550 calls taken at the Statewide Benefits Office and 1,230 at the Pension Office. The help desk at PHRST took 1,500 calls and reset 3,000 passwords. About 20 percent of employees logged onto e-benefits to verify or make changes. Of 34,000 benefit eligible employees about 7,700 used e-benefits. There were 5,000 COBs completed electronically. About 2,000 were not completed. Over the next month, Statewide Benefits will work with agencies and employees to get those submitted. If not completed, the spouse is sanctioned and claims are paid at 20 percent. VSP (vision) had 1,000 new enrollees. In the fall we will release a Request for Proposals for a new vision plan effective 7/1/2011. Ms. Visalli added that the state picked up the increase for employee's share of medical premiums for FY2011. The Joint Finance Committee (JFC) voted for funding to avoid use of the health fund reserve to cover expenses in FY2011. The JFC will continue to meet June 14, 16 and 18. All decisions of the JFC are subject to change pending passage of the operating budget by the General Assembly.

In-Vitro Fertilization (IVF) changes for FY2011 were revisited due to many employee calls and emails. In February 2010, the SEBC voted to impose a 25 percent co-insurance on all infertility coverage,

expanded from just IVF and changed the lifetime limits to $10,000 for medical and $15,000 for prescriptions. They grandfathered those who were active in IVF (receiving services) or approved for IVF since January 1, 2009. They were allowed to retain the prior combined $30,000 lifetime limit; however, a 25 percent co-insurance was imposed for all services received after 7/1/2010. It is possible to not impose the 25 percent co-insurance on just the grandfathered group. In depth discussion with questions and answers followed. Justice Berger was concerned about giving this benefit back to a small group while not giving back other benefits that had been taken from all employees. Mr. Adams was concerned about the benefit being changed midway thru a process without advance notice having been given. Controller General Larson made a motion to grandfather in those who are in the process or approved for IVF up to July 1, 2010 from both the lifetime limits and the 25 percent co-insurance. Mr. Adams seconded the motion. Upon voice vote Mr. Smith, Commissioner Stewart, Controller General Larson, Director Visalli and Mr. Adams gave approval. Justice Berger abstained from voting. Secretary Cook was not present. The motion carried.

Approval of Minutes

After review of the SEBC March 29, 2010 meeting minutes, Ms. Visalli asked for a motion to approve them. Controller General Larson made the motion to approve the minutes and Mr. Adams seconded the motion. The minutes were approved with a unanimous voice vote.

Health Fund Financials – (Handouts)

Ms. Oravez explained the March and April Fund and Equity reports. In March there was additional revenue of $4.85 million which was attributable to a Medco prescription rebate payment. The March ending balance was ($1.45M). April had $44M in revenues and $43M in operating expenses. The ending balance in the fund as of April 30th was ($529,119).

Health Care Reform Updates

The Early Retiree Reinsurance Program (ERRP) - Mr. Morfe, Aon (handout)

- Plan sponsor participates in program of:
    - Reimbursement for each non-Medicare plan participant over age 55, not in active employment with the employer
        - With gross claims incurred and paid over $15,000 and under $90,000 in a plan year
    - Reimbursement for spouse or dependents of these retirees, regardless of age or Medicare status is also available
- Gross claim includes retiree cost sharing (deductible, co-pays, coinsurance)
    - HHS interim rules require evidence that retiree paid their cost sharing
- Includes medical and Rx costs, requiring vendor collaboration or data aggregator

NOTE: More guidance is needed on the cost reporting

ERRP Overview

"First Come First Serve" – One time application opens June 2010:
$5 billion limit for the entire period program offered
Ceases 12/31/2013 in anticipation of Exchanges in 2014

- Applications must be submitted and approved before claim submission

- Incomplete applications will be rejected
- Re-application required but move to "back of the line

Applications must include:

Plan sponsor information	Identified benefit options
Disclosure on use of reimbursements	Projected reimbursements for two years
Attestation to policies for fraud, waste and abuse	Disclosure on programs in place to reduce member costs for high-cost and chronic conditions

- Plan must have programs / provisions in place designed to reduce costs for members with chronic and high-cost conditions
  - Consider
    - large case management programs
    - disease management programs (Rs and medical plans)
    - plan design incentives for specific diseases/conditions
  - Must describe on application
- Plan sponsors must have programs and policies in place to detect fraud, waste and abuse
  - Must attest to existence on application
- Payments used to "reduce plan's costs" or reduce retiree contributions or cost sharing
  - HHS requires plan sponsor to maintain its level of contribution to the plan
  - Suggests use of reinsurance to offset increase in plan sponsor's costs for plan as a whole – not just early retiree portion
  - Must disclose use of reimbursement, and 2-year projection, on application

Guidance Issues:

- Interim Final Regulations Issued May 3rd
- Comment period through June 4th
- Significant preamble discussing "thought process"
- Significant leverage of Retiree Drug Subsidy process and definitions
- Many differences from RDS
- Application will be the first major hurdle for plan sponsors
- Significant preparatory work required for the application

ERRP Application Process

- Steps Involved

Identify benefit options and develop descriptions	Define Plan Year for application
Identify chronic / high-cost conditions	Evaluate programs and plan designs in place to reduce member costs for chronic / high-cost conditions
Estimate the potential reinsurance payment	Determine split of reinsurance payment between reductions in plan sponsor and member costs
Evaluate or develop programs to detect fraud, waste and abuse	Formalize agreements with vendors
Develop initial list of eligible early retirees and dependents, by benefit option	Determine roles and responsibilities for application

Discussion followed with questions and answers.

Young Adults and the Affordable Care Act - Mr. Morfe, Aon (handout)

Benefit Mandate

- Dependent coverage must be made available for health plans (medical, not dental or vision) until age 26 by plan year beginning on or after September 23, 2010 (effective date for this provision of health care reform) which is July 1, 2011 for State of Delaware Group Health Plan.
- Plans in existence on March 23, 2010 (grandfathered plans) may exclude adult children who are eligible to enroll in an employer-sponsored health plan. This exception no longer applies for plan years beginning on or after January 1, 2014.
- Married and unmarried children qualify
- Children and spouse of dependent children are excluded
- Student requirement is removed
- No requirement of financial support

Financial Aspects

- May not charge more than similarly situated individuals/other eligible dependents who did not lose coverage due to loss of dependent status, i.e., included in parents' parent/child or family coverage
- Estimated cost to State Group Health Plan is $5M annually
- Value of any employer-provided health coverage for employee's child is excluded from employee's income through the end of the taxable year in which the child turns 26 (if coverage is extended to the end of the calendar year vs. terminating on 26th birthday.)

Implementation Requirements

- Must provide written notice to all benefit eligible employees and pensioners
- Must provide 30 day enrollment period

Existing Issues for State of Delaware

- Conflict exists with current Delaware Code
    - Delaware Code calls for coverage of SOD dependents to age 21, or age 24 if full time student
    - "Adult dependent" program for non-students aged 21-24 fully insured with carriers based on Delaware Code requirements
- Early adoption has been strongly encouraged at the federal level and BSBSD and Aetna are implementing for insured business as follows:
    - Keeping dependents enrolled who would otherwise age out
    - Not reenrolling dependents who had been terminated but are now eligible until beginning of plan year on or after September 23, 2010

Dependents Impacted by Change

- One group is currently enrolled under parental plan:
    - About to age out, due to end of student status/graduation from college
    - About to age out – attaining age 24
    - Turned 21 in 2010 – coverage would end December 31, 2010
- One group is not currently enrolled under parental plan:
    - Over 21 but not full time students
    - Over 24
    - Currently enrolled in Adult Dependent Plan
    - COBRA participants

Implementation Date

- As of date provided by federal mandate - first of plan year after September 23, 2010 effective date of legislation – which would be July 1, 2011 for State of Delaware Group Health Plan
- Implement prior to July 1, 2011 if State legislation is proposed and passed to amend Delaware Code's definition of eligible dependent child to age 26
- Explore option to increase dependent age to 26 with dental and vision vendors as Request for Proposals or contract renewals are negotiated for fiscal year 2012 and beyond as these are fully insured benefit plans

There was in depth discussion with questions and answers. Federal implementation is not required until July 1, 2011. Exactly how many dependents this will affect is unknown. It could be 5,000, particularly if many in this age group are unemployed. Many inquiries have been received from employees wanting this implemented as soon as possible. Implementation requirements include written notice to all benefit eligible employees and pensioners. A 30 day Open Enrollment period would have to be held. There is a conflict with Delaware Code that needs to be changed by the legislature before it can be implemented. Once changed, the earliest possible date it could happen would be September 1, 2010.

Justice Berger made a motion as amended, that SEBC support implementation of the mandate on September 1, 2010, or as soon thereafter as possible, subject to obtaining necessary legislation. Because the SEBC is not specifically authorized to draft legislation, Justice Berger offered to draft and have it introduced on her own. Ms Visalli stated that she could support a motion, if the committee wanted to be vocal, that the SEBC would authorize coverage if instructed to provide it. Ms. Visalli also suggested that the motion is inappropriate because the SEBC likes to offer public comment for significant motions. Mr. Kerber explained that the role of SEBC is to administer and follow the Delaware Code. Two other key factors to consider are the estimated $5M annual cost to the Group Health Insurance Program and that the public and State Employee Benefit Advisory Council needs time to provide comments. The motion was not seconded.

Update on Plan Changes Effective July 1, 2010

Ms. Rentz explained that a Request for Proposals would be released in the fall of this year for vision for the plan year beginning July 1, 2011 and for dental, no later than the fall of 2011 for the plane year beginning July 1, 2012.

At the March 29, 2010 SEBC meeting a contract was awarded to Alere effective July 1, 2010. It was stated that Alere would appear before the committee with program details.

Alere – Presented by Zach March and Betsy Piazza (handout)

An overview of the Alere program and services were presented including information related to Alere's member-centric programs, single-source solutions and proven outcomes. The Personal Health Support Model containing services to support wellness, disease management, complex case management and provider integration was explained. Specifics were provided as to how the delivery model allows and encourages both participant and physician interaction and how coaching and in-home monitoring empowers and engages the participants. A description of the 24/7 Nurse line was also provided.

Highlights of the implementation and program strategy for wellness were discussed as well as the wellness program components. Goals and objectives related to awareness and engagement along with ideas for incentives were shared.

The following dates were also communicated:

A. Disease Management Launch July 1, 2010
B. Nurse line 24: Launch July 1, 2010
C. Health Portal: Launch July 1, 2010
D. Wellness: Launch October 1, 2010
    a. Health Coaching
    b. Healthy Living Programs
    c. Health Risk Assessment
    d. Biometric Screenings
    e. On Site Seminars

There were no questions.

Ms. Visalli referenced Executive Order 19 that Governor Markell signed on March 20th. It also addresses wellness issues.

Med Solutions Update – Ms. Lakeman

Both vendors met with the Insurance Commissioner's Office in April. Aetna agreed to approve Med Solutions Cardiac Nuclear Stress tests for 60 days. They will continue this course of action until the Commissioner's Code of Conduct review is completed. Blue Cross is doing the same. They have completed a thorough review of all their high tech imaging utilization management and have identified a few issues.

Based on that review they will be putting the following processes in place. Med Solutions will continue to review the case and provide an approval or denial. If Med Solutions does deny the test and it is appealed, and they continue to feel the denial is appropriate, they will refer the case to Dr. Kaplan, Blue Cross Chief Medical Director. He will review and render a decision. If he feels an independent reviewer is necessary, he will send it to one for further review. Blue Cross will be resuming their review of MRI, CAT scans and PET scans in mid June after discussion with the Department of Insurance. They will have a 60 day break in period where doctors will contact Med Solutions for review of the request to be approved or denied. During the 60 days, all tests will ultimately be approved by Med Solutions; however, if there is a reason that Med Solutions feels the test should otherwise be denied they will utilize this 60 days to contact the providers and get them comfortable with the guidelines and rationale behind the denial. Blue Cross will also resume review of Cardiac Nuclear Stress testing following discussions with the Insurance Commissioner's Office.

In the meantime, it was suggested that the Committee continue the course of action as agreed to begin July 1. Blue Cross confirmed that the SEBC can terminate the contract with Med Solutions at any time in the process with 30 days notice.

SEBAC Comment

None.

Public Comments

Mr. Barchak, DSEA, stated that there are major changes in health care policy being proposed in the last 13 days of the legislative session to change the basic level of health care for new employees that has previously been no cost to existing employees. He feels the costs are excessive and will force employees to not take health insurance coverage and put their children on health care assistance. SEBC has not had time to explore alternatives with help from consultants and actuaries. Thirteen days is not enough time to make these decisions that impact the health care benefits of thousands of public servants from this time forward. He encouraged SEBC to make their voice heard and not support rushing health care policy through during this legislative session.

Mr. Leiter, state employee, had many questions which he was asked to submit in writing to the Committee for response. Topics of his questions were: Elimination of Double State Share; In-Vitro Fertilization; Medco prescription rebates and health coverage for dependents to age 26. He stressed that when changes are made to benefits they need to be made public and not just put on web sites as not all have computer access.

Other Business

Ms. Lakeman distributed an informational handout for New Pension and Health Care Benefits for employees hired after January 1, 2011.

Ms. Visalli explained the need to move into Executive Session for discussion of a health appeal. There would be no additional business following Executive Session.

Ms. Visalli asked for a motion to go into Executive Session. Mr. Adams made the motion and Mr. Smith seconded the motion. There was a unanimous voice approval. The Committee moved into Executive Session at 3:58 p.m.

At 4:17 the SEBC public session reconvened. Ms. Lakeman asked for a motion to deny the health benefit appeal discussed in the Executive Session. Commissioner Stewart made the motion and Mr. Smith seconded the motion. Upon unanimous voice approval the motion passed.

Ms. Visalli asked for a motion to end the meeting. Commissioner Stewart made the motion and Mr. Smith seconded. After a unanimous voice approval the meeting ended at 4:18 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB